III. QUALITY OF CARE OVERSIGHT AND REIMBURSEMENT

Ensuring quality of care in nursing homes has always been an objective of responsible government agencies. The federal and state oversight and funding systems for nursing homes are extremely complex, but beyond continued stringent enforcement, the gradual change of focus emerging for these systems is one that:

- *supports facility risk management, quality improvement, and compliance programs as methods to achieve quality improvement;*
- *expands the amount of historical facility performance data and quality indicator information available to allow informed choice for consumers;*
- *emphasizes the critical importance of adequate staffing to achieve quality improvement;*
- *acknowledges caregivers that provide exemplary care; and*
- *considers quality indicators and positive outcome data in the methodology for paying nursing homes to encourage quality improvement.*

> "The structures, incentives, and forces at work in the U.S. health system produce exactly what we should expect in the quality of care for chronic disease: highly variable patterns of care, widespread failure to implement recognized best practices and standards of care and the persistent inability of provider systems to achieve substantive changes in patterns of practice."
>
> – Molly Coye, Chief Executive Officer of the Health Technology Center in "No Toyotas in Health Care," *Health Affairs (Nov/Dec 2001).*

The perception of whether quality care is being provided in nursing homes, can directly affect the cost and availability of liability insurance. Experts, however, struggle to define quality of care in concrete terms. The purpose of nursing homes, described in federal law, hints at the complexity involved: " A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, of each resident." [1]

Insurers, evaluating the effectiveness of current oversight and reimbursement actions, see a greater degree of risk in today's market for writing liability

*insurance. Increased numbers of claims from **civil actions** indicate that consumer expectations regarding quality of care are not being met.*

*Nationwide and in California, dissatisfaction with the quality of care provided in nursing homes appears significant. Elder care abuse cases are in the headlines. Federal and state oversight activities are criticized as inadequate. Since 1997 the General Accounting Office (GAO), the investigative arm of Congress, has published dozens of reports related to quality and reimbursement issues for nursing homes. Governor Davis began developing his **Aging with Dignity Initiative** soon after taking office because of his desire to ensure that elderly and disabled Californians have high quality LTC options available.*

REGULATION AND OVERSIGHT OF NURSING HOMES

Nursing homes can be either freestanding SNFs, meaning that they are not a part of any other health care facility, or hospital based, meaning they are a distinct part within a general acute care hospital (DP/SNF). They can be for-profit facilities, meaning that they are investor-owned, not-for-profit, or operated by the government. California has 1440 licensed nursing homes with 130,821 available beds. Nursing homes provided 38,271,700 patient days of care in 2001 (see Table 4, page 41, for detail). Over 80 percent of the nursing homes in California are for-profit, freestanding facilities.

Nursing homes are one of the most regulated of health care providers. A DHS team of trained health professionals conducts an intensive **survey** of each California nursing home at least once every 9 to 15 months. The inspections average over 150 hours and include not only examination of administration and physical plant, but also an assessment of the quality and adequacy of care. The survey team members review quality indicators based on patient assessment data, and observe, interview, and review medical records to determine compliance with federal and state requirements. Surveyors conduct onsite visits to investigate all **complaints** against nursing facilities. If the complaint indicates there may be an immediate and serious risk to a resident, the investigation will take place within 24 hours of the call.

Certified nurse assistants (CNA), provide 60-80 percent of the care in nursing homes. While **Registered Nurses (RNs)** and **Licensed Vocational Nurses (LVNs)** are responsible for the remaining direct care services. CNAs must be certified by DHS before they can provide care in a SNF. To become a CNA, an applicant must pass a physical exam, submit fingerprints prior to resident

contact, and pass a background check that indicates no criminal convictions for Penal Code provisions specified in law. The applicant also must complete a minimum of 160 hours of training in a DHS- approved program and successfully complete a competency exam conducted by a DHS-approved testing vendor.

Vulnerable Residents
It is easy to understand why so much time and energy is focused on this segment of healthcare in the United States. The residents of nursing homes are typically over 75 years of age, very ill, very frail, and often disoriented. They are in a nursing home for the purpose of continuous access to skilled care.

Despite regulation, a February 2002, national survey by *The NewsHour with Jim Lehrer,* the Kaiser Family Foundation, and the Harvard School of Public Health found that nursing homes are not seen as a particularly positive care choice:

> Majorities of the public believe that nursing homes are understaffed…, that nursing home staff are often poorly trained, that at least some nursing home residents are abused and neglected, that many residents do not have enough privacy…and that many residents are lonely.[2]

Aging with Dignity

- ✓ **Care Options**
- ✓ **Tools to Choose**
- ✓ **Qualified Care Givers**
- ✓ **Provider Incentives**
- ✓ **Effective Oversight**
- ✓ **Financial Stability**
- ✓ **Quality of Care**

State Strategy to Improve Care for the Aging
Upon taking office in 1999, Governor Davis quickly ascertained that improvements were necessary to the system of long-term care for Californians. He based his comprehensive "Aging with Dignity Initiative" on the principles that:

- Consumers need options for meeting their health care needs and the tools to make wise choices among their options;
- Caregivers need to meet appropriate qualifications and be given support and incentives to excel; and,
- Government needs to maintain an effective and responsive regulatory framework to ensure the quality of services.

Another major focus of the Governor's approach to nursing homes within the Initiative was his recognition of the direct relationship between quality of care and the financial stability of the facility where care is being provided.

The Administration strategy utilizes statutory changes, budgetary provisions, and administrative actions and includes components to help seniors stay at home,

increase the availability of community based alternatives to nursing homes, and enhance the quality of care in nursing homes. Current State activities to improve quality oversight in nursing homes and to modify the Medi-Cal rate methodology, are examples that highlight the policy focus for nursing homes within the Aging with Dignity Initiative.

Federal Medicare and Medicaid (Medi-Cal) Programs

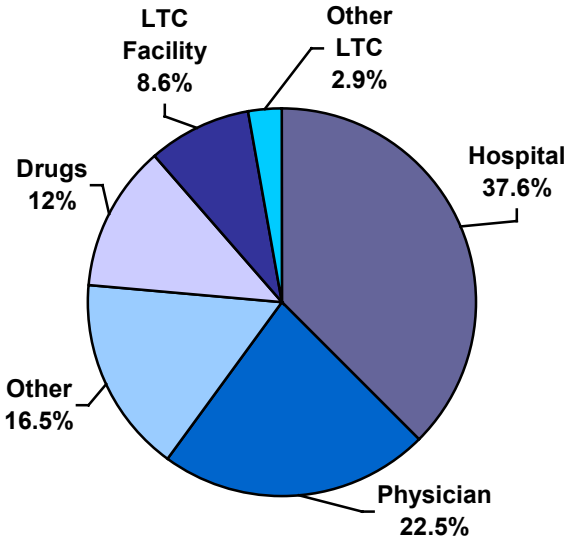
Nursing home costs represent almost nine percent of U.S. personal health spending. Forty-six percent is paid by Medicaid and 11.8 percent by Medicare.[3] In California, the total estimated Medi-Cal expenditures for fiscal year 2002-03 for SNFs and ICF/DD facilities is $3,104,038,000. This represents approximately 12 percent of all Medi-Cal expenditures. Over two-thirds of California nursing home payments are from public funding sources.

OVERALL SPENDING

Out of all U.S. personal health spending, $117 billion was spent on long-term care services in 1998. Spending for nursing homes and intermediate care facilities for the mentally retarded (ICF/MR) represented 75 percent of all long-term care spending.

FIGURE 3.

Personal Health Spending in the U.S. 1998



Source: *Urban Institute, 2001*. Based on Office of the Actuary, National Health Statistics Group, Personal Health Care Expenditures, HCFA, DHHS, 2000.

Since the majority of SNF payments are made by government entities, Medicare and Medicaid become the driving forces for change in how care is provided to nursing home residents. Federal efforts to improve the two programs have focused on strengthened oversight, residents' rights, increases in staffing, and improved quality of care.

Medicare is the federal health insurance program for individuals age 65 and over, and for specified individuals with disabilities. The program covers nursing home services for beneficiaries discharged after a qualifying hospital stay, for up to 100 days. Once beneficiaries' coverage lapses, if they have assets, they would **self-pay**. If they do not have assets, or if they "spend-down" their assets, they become **Medicaid (Medi-Cal** in California**)** eligible.

DHS contracts with the CMS to conduct nursing home surveys that monitor quality of care and enforce compliance with federal requirements. DHS also **licenses** all nursing homes in California and is responsible for ensuring that all residents are safely transferred if a facility is to be closed. Only 25 nursing homes in the state are "licensed only," meaning they serve private-pay residents only. All other SNFs are **certified** to receive Medicare or Medi-Cal reimbursement, or both. Virtually all facilities in this State are therefore required to meet the quality compliance standards set by the government financing programs.

CHANGES IN THE FOCUS OF QUALITY OVERSIGHT

Measurement and Comparison of Quality Indicators and Outcomes
Almost 15 years ago, the federal government established a framework to ensure the provision of high quality services to nursing home residents whose care is paid for by Medicare and Medicaid. In the '70s and '80s, serious abuses had been identified nationwide in the treatment of some nursing home residents. The **Omnibus Budget Reconciliation Act of 1987 (OBRA '87)** contained major changes to federal methods of oversight to address these issues.

The revised monitoring approach established in OBRA '87 was intended to be outcome-based, seeking to measure positive or negative results of the care provided. It focused on whether a facility was appropriately assessing its residents, planning a course of action to meet their multiple needs, and taking actions that were responsive to residents' wishes, capabilities, and changing status.

Providing care to residents of LTC facilities is complex and challenging work. It utilizes clinical competence, observation skills, and assessment expertise from all disciplines to develop individualized care plans for residents. The **Resident Assessment Instrument (RAI)** was developed by the federal government to help facility staff to gather definitive information to be addressed in an individualized care plan.

Since OBRA 87, the federal framework has continued to evolve towards a data driven system that can use quality and compliance data to target poor performing facilities for further review. The availability of more accurate automated data also

allows Medicare and Medicaid reimbursement systems to utilize prospective rates that consider requirements and needs of the resident in determining payment. Table 5 (see page 46) summarizes some of the basic policy and reimbursement changes that have helped define the current Medicare and Medicaid focus.

CMS Quality Demonstration Project

CMS has taken significant steps to emphasize quality of care, outcome measurement, and empowerment of consumers through provision of detailed information from which to evaluate SNF care. In January 2002, CMS began a five-state demonstration to identify, collect, and publish nursing home quality information in Colorado, Maryland, Ohio, Rhode Island, and Washington. The quality measures identified would be recognized and accepted by consumers, clinicians, and healthcare providers. CMS began publishing the information on April 17, 2002, to help make people aware of how performance differs across nursing homes. Following the pilot project, CMS will refine and expand the initiative to include risk-adjusted quality information from nursing homes in every state. The national project is scheduled to begin in November 2002.

The Quality Indicators (QIs) include percentage of:

- Residents Who Need More Help Doing Daily Activities
- Residents with Pressure (Bed) Sores
- Residents Who Lost Too Much Weight *(removed in the final version)*
- Residents with Pain
- Residents with Infections
- Residents in Physical Restraints
- Short-Stay Residents Who Improved in Walking
- Short-Stay Residents with Pain
- Short-Stay Residents with Delirium [4]

Financial Stability and Quality Incentives

In California, Governor Davis began implementing his Aging with Dignity Initiative in 2000. The nursing home reform legislative component, AB 1731 (Chapter 452, Statutes of 2000) emphasized improved information for consumers, substantial resources to support direct caregivers, recognition of exemplary facilities, and tougher enforcement provisions. The legislation also introduced provisions to focus on the direct relationship between quality of care and the financial stability of the facility where care is being provided (see Table 5, page 46).

Financial Stability

Since 1998, facilities have been required to notify DHS in writing within 24 hours of filing a bankruptcy petition. In order to protect residents during any transfer that might occur due to bankruptcy, when the bankruptcy court appoints a trustee, DHS must notify the trustee of the requirements for operating a licensed LTC facility.

AB 1731 provisions went substantially beyond the requirement for notification of bankruptcy filing. Facilities now are required to report to DHS whenever early symptoms of financial distress occur. When a facility submits a licensing application, renewal, or **change of ownership (CHOW)** request, DHS places greater scrutiny on the companies that manage nursing homes as well as the licensee organization. DHS also established a **SNF Financial Solvency Advisory Board**. The Board consists of a panel of experts to advise DHS of appropriate financial standards for facilities and methods to monitor facility financial status.

Quality Incentives

AB 1731 also included a **Quality Awards Program** to encourage and acknowledge efforts to provide the highest quality of care. Provisions require awards to SNFs with performance histories that indicate they provide exemplary care to residents. Funding was also made available for an **Innovative Grants Program** to encourage projects that demonstrate methods to improve quality of care and quality of life for residents.

CARE GIVERS AND QUALITY

Aging with Dignity Focus on Nursing Home Staffing

Both federal and state regulatory authorities recognize the importance of adequate staffing to ensure quality of care in SNFs. California now has one of the highest direct care staff standards. One of the major principles guiding the Governor's Aging with Dignity Initiative is its emphasis on the caregivers, both ensuring that they have adequate qualifications and that they have adequate incentives to provide care. Staffing costs account for 54 percent of total freestanding SNF costs, and CNAs provide the majority of direct care in nursing homes.

Governor Davis included provisions in Assembly Bill 1107 (Chapter 146, Statutes of 1999) that increased California's minimum nursing staff requirement to 3.2 hours of direct patient care per day effective January 2000. This gave California the third highest standard in the country at that time. The change was in direct response to concerns about the effect that relatively low levels of direct patient care staff in nursing homes had on quality of care.

AB 1731, the Governor's nursing home reform bill, continued this focus on direct care staffing. The bill required DHS to submit a report to the Legislature by May 2001 that addressed the adequacy of the new 3.2 hours per patient day standard to ensure quality of care. While the report recognized the importance of adequate staffing to ensure quality of care, it concluded that sufficient empirical data were not available to recommend an increase to the minimum staffing requirement.

In the legislative report, DHS instead recommended the development of a rate-setting system that reflects the costs and staffing levels associated with quality of care for nursing home residents. It also recommended future consideration of converting the minimum staffing requirement from the current hours per patient day standard to a staff to patient ratio standard. This change would allow residents and their families, facility employees, and state inspectors to determine easily whether or not a facility is in compliance. Assembly Bill 1075 (Chapter 684, Statutes of 2001), included language to implement these recommendations from the May 2001 report (see Table 5, page 46).

Federal Staffing Research

> "…for virtually all types of nursing staff, there is some ratio of staff to residents below which residents are at substantial risk of increased quality problems."
>
> *—Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase I) 9-16.*

In July 2000, the federal Health Care Financing Administration (HCFA, now CMS) published a *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes (Phase I).* The Phase One study findings indicated that it is possible to identify significant staffing thresholds. The first threshold, HCFA's "Minimum Staffing Level," is the threshold below, which care of residents is likely to be compromised.

The federal Department of Health and Human Services (DHHS, HCFA/CMS' parent Agency) issued the Phase II Report in March 2002, but was unwilling to establish mandated staffing requirements based on either the Phase I or Phase II report findings. In a letter accompanying the Report, submitted to Congress, DHHS indicated that:

> "The question of the relationship between the number of staff and quality of care is complex and the Phase I and Phase II studies made good faith efforts at addressing the question. However, the Department has concluded that these studies are insufficient for determining the appropriateness of staffing ratios in a number of respects. Specifically, we have serious reservations about the reliability of staffing data at the nursing home level and with the feasibility of establishing staff ratios to improve quality given the variety of quality measures used and the perpetual shifting of such measures."[5]

Consumer advocates point to the study, however, as validation that "nursing homes have too few workers to care properly for residents, putting them at significant risk for such health problems as bedsores, blood borne infections, dehydration, malnutrition and pneumonia." [6]

Direct Care Staffing is a Consideration for Liability Insurers

Staffing also is found at the top of the list when insurers evaluate which facilities appear to be "good risks." The Texas Department of Insurance (TDI) has created a tier-rating system of nursing homes that considers a number of factors that determine risk of insurability. The rating system, however, only applies to nursing homes applying for admission to the state's **Joint Underwriting Association (JUA)**. At this time only one nursing home has obtained coverage under the JUA. The system is an important start in developing a public rating system of the nursing home industry. It includes:

- Past Claims Experience;
- Quality of Care Rating (An Online State Rating System);
- Staff Ratios;
- Tenure and Credentials of Key Personnel;
- Risk Management, Loss Control, and General Safety; and
- Ombudsman Program Evaluation.[7]

CHANGES IN NURSING HOME REIMBURSEMENT FOCUS

Government, through administration of the Medicare and Medicaid Programs, is the major provider of funding for nursing home care in the United States. For this reason, it retains oversight responsibility and sets the parameters for services provided with those funds.

A shift in focus is occurring at the federal and state level, to utilize quality indicators and positive outcome data from its system of oversight, in reimbursement methodologies structured to encourage quality improvement. The **Office of the Inspector General (OIG)**, the federal organization with primary authority for protecting the Medicare program and its beneficiaries, has also instituted several programs that rely on collaboration, cooperation, and voluntary compliance on the part of the health care industry to fight health care fraud and abuse.

Medicare

Medicare payments are currently based on a Prospective Payment System (PPS) that establishes a per diem payment for each Medicare resident, adjusted to reflect differences in resident characteristics and service needs. The changes in the method of payment were part of the Balanced Budget Act of 1997 (see Table 5, page 46). Federal testimony, presented before the Senate Special Committee on Aging on September 5, 2000, asserted PPS was necessary to curb escalating health care costs.[8] The previous cost-based reimbursement method, combined with a lack of appropriate program oversight, had provided few checks on the growth in Medicare spending for SNF services.

Implementation of New Medi-Cal Reimbursement Methodology

Medicaid (or Medi-Cal in California) is the federal assistance program for low-income and other eligible individuals with healthcare needs, implemented in partnership with state governments. The state establishes an approved program, and the federal government will pay a percentage of the state's claims expenditures, or match the state Medicaid payments.

Medi-Cal currently uses facility cost data reported on the integrated long-term care disclosure and Medi-Cal cost report to derive a flat rate structure for paying nursing homes (see insert). AB 1075, requires that California adopt a facility-specific rate-setting system for nursing homes by 2004 (as well as the changes to minimum staff standards discussed earlier).

DHS has contracted with Tucker Alan, Inc., to devise a Medi-Cal LTC reimbursement methodology to encourage access to services, high quality resident care, appropriate wages and benefits for nursing home workers, provider compliance with requirements, and administrative efficiency.

CURRENT MEDI-CAL RATE DEVELOPMENT PROCESS

To develop rates DHS currently uses:
- ✓ facility cost data reported on the integrated long-term care disclosure; and
- ✓ Medi-Cal cost reports

DHS consults with provider associations and others to gain support of the assumptions used.

Rates are updated August 1 each year.

Each facility's rate is a prospective determinate of:
- ✓ direct patient care labor;
- ✓ capital-related assets; and
- ✓ other considered costs.

Reported costs are trended by a DHS-determined economic indicator factor.

Peer groupings are developed based on geographic factors and number of beds, as appropriate.

Tiers of payment are established based on median costs of the peer group.

Capital-related medians are limited by a ceiling at the 75th percentile and a floor at the 25th percentile.

In its review of quality of care issues, Tucker Alan intends to:
- Interview chief architects of the Medicare system of minimal data set (MDS) and quality indicators.
- Determine appropriate data sources for analyzing quality of care information in California facilities.
- Review quality of care incentives used by other state Medicaid agencies.
- Evaluate the on-going California project regarding quality of care, the web-based Consumer Information System.
- Identify potential quality of care indicators.

DHS is to report progress periodically to the Legislature on development of the rate-setting system.

Reimbursement Oversight

Multiple units within DHS are involved in oversight of nursing home payments. DHS Medical Care Services (MCS) and Electronic Data Systems (EDS), the fiscal intermediary contractor, monitor and administer the reimbursements to nursing homes. The Medi-Cal Rate Development Branch establishes rates, using data from the cost reports submitted by providers to OSHPD and the results of cost audits conducted by the Audits and Investigation (A&I) Division. In the past, L&C involvement in reimbursement oversight has been limited. The L&C focus is licensing of nursing homes, compliance with federal and state quality standards and enforcement actions against facilities.

Blending Reimbursement and Quality

AB 1075 requires a facility-specific rate setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. The workload associated with a facility-specific rate-setting process is significantly more complex than the current flat rate system. At a minimum, such a system may bring into consideration the case mix of nursing facility residents, including their clinical condition and resource needs.

In order to develop an appropriate system, L&C professional staff need to validate the accuracy of the resident assessment, **Minimum Data Set (MDS)**, data submitted by facilities, comparing them to actual medical records. In addition, since the incentive exists to "over-report" costs in a case mix system, an expanded A&I Division audit program and expanded data are needed.

Developing this new Medi-Cal reimbursement methodology, combined with increasing emphasis on quality indicators, outcome measurement, staffing and financial solvency of nursing homes, requires greater integration of oversight and reimbursement functions within DHS.

Liability Insurance and Medi-Cal Rates

The current Medi-Cal rate methodology provides for a rate adjustment to reflect changes in state or federal laws and regulations (and may recognize other extraordinary costs) that would affect the historical costs of the facilities, commonly referred to as an "add-on." During the 2000/2001 long-term care rate study; DHS recognized a rate add-on to certain LTC providers to reflect an acknowledgment of the increasing cost of liability insurance. The liability insurance "add-on" was approximately $1.09 per patient day.

DHS is analyzing industry requests (and supporting documentation) to increase rates in response to rising liability costs. Details regarding the methodology to be implemented in response to AB 1075 are not yet available, as the rate methodology study is in the preliminary stages. It is unknown at this point, how or whether liability insurance will be factored into this new rating formula.

Opinions differ as to the appropriateness of such a rate adjustment. Consumer advocates and providers disagree about the cause for problems with availability and cost of liability insurance. Liability insurance, by definition, covers a facility's legal liability that might result from injuries to residents or others. Consumer advocates and attorneys believe that increases in the frequency and amount of settlements and awards in lawsuits against nursing homes reflect poor care. In the words of one advocate, "insurance rates increase as risk increases among nursing homes that are not providing adequate quality of care."[9]

Providers believe that the prevalence of litigation is due to overly aggressive attorneys that actively solicit cases, encourage suits and inflate claims. Providers also do not see an "empirical relationship between facilities' experiences and the increased cost" of liability insurance.[10] Facilities providing a high level of care are being penalized along with those providing poor care.

In developing the Medi-Cal facility-specific rate methodology, the relationship between increased administrative costs for liability insurance, and the cost for provision of services will need to be carefully studied.

NEED FOR PRIVATE PAYMENT FUNDING SOURCE

Increasing liability insurance costs are particularly problematic for government payers. Reimbursement cannot be separated from the fiscal well being of a facility, and insolvency has major implications for the state agency, in terms of negative impact on residents and an unanticipated financial burden for taxpayers.

LTC Insurance Affect on Medicare and Medi-Cal

CMS noted in a recent financial report that nursing home per diem rates steadily decline as a resident's financial eligibility shifts from Medicare to private pay to Medicaid. The report also indicates that the Medicare rate of growth in spending has dropped significantly for nursing homes since the Balanced Budget Action of 1997."

The federal fiscal year (FY) 2003 budget includes an above-the-line tax deduction for the cost of LTC insurance premiums. The deduction would be available for the employee's share of the cost of employer-provided coverage if the employee pays at least 50 percent of the cost. The deduction would start phasing in 2004 and by 2007, taxpayers could deduct 100 percent of their long-term care premium costs. The federal proposal is projected to cost $21 billion over 10 years.[11]

Since Medi-Cal already is paying for the majority of nursing home costs in California (51 percent), LTC insurance is the only factor that potentially can reduce government's role in financing nursing home care.

California Partnership for Long-Term Care

In order to support expanded use of LTC insurance by Californians, DHS established an innovative program, the **California Partnership for Long-Term Care**, in cooperation with a select number of private insurance companies. These companies offer high quality policies that must meet stringent requirements set by the Partnership and the State of California.

"A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue.

Very few aging Americans buy private long-term care health insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design.

Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressures on the public programs—Medicare and Medicaid."

—CMS Health Care Industry Market Update Nursing Facilities (2/6/02).

The Partnership's LTC policy offers incentives to individuals to secure long-term care coverage. When the policyholder needs care, the policy pays for the care in a manner similar to those used by other high quality long-term care policies. In addition, however, for each dollar the policy pays out in benefits, it also entitles the policyholder to keep a dollar of assets should she or he ever need to apply for Medi-Cal services.

The Partnership seeks to protect policyholders from having to spend down assets, and it seeks to protect those assets from Medi-Cal estate recovery. It also is actively pursuing other efforts to increase penetration as a way to develop and strengthen a different funding source other than Medi-Cal:

- A new brochure published and aimed at adult children to consider how their parents' lack of LTC insurance will affect them should their parents need LTC.
- An Invitation to Participate to procure assistance marketing the Partnership's product to middle-income consumers via the work place. The State of California as an employer now offers a LTC policy to state, county employees, and other civil servants.
- The Partnership is also working closely with provider organizations, such as California Association of Health Facilities (CAHF) in joint consumer education efforts.

Implications

Government licenses all nursing homes, pays for the majority of nursing home care in this country, and regulates to prevent fraud and abuse and to ensure quality care. State and federal nursing home regulators are now implementing systems for quality of care oversight and reimbursement, that focus on the same quality data insurers need to evaluate the risks involved in providing liability insurance coverage to those same nursing homes.

The nature of the insurance industry is to gain predictability and consistency. By further integrating performance and quality improvement into its nursing home monitoring and oversight system, Medicare and Medi-Cal will be providing information useful to evaluating positive performance of nursing homes in the areas of quality and staffing. This more complete profile of provider performance can assist not only consumers, but also the insurers who provide liability coverage. Currently the main data available on nursing homes relates to negative performance and enforcement remedies.

TABLE 4.

CALIFORNIA NURSING HOME TREND DATA

Nursing homes can be either freestanding (SNF), meaning that they are not a part of any other healthcare facility, or hospital based, meaning they are a distinct part within a general acute care hospital (DP/SNF). They can be for-profit facilities, meaning that they are investor-owned, not-for-profit, or operated by the government (state or local).

Nursing Home Ownership Type

Freestanding

	Facilities	Percentage	Beds	Percentage
Investor Owned	1,028	84.7%	104,171	87.9%
Not-for-Profit	179	14.8%	13,579	11.5%
Governmental	6	0.5%	751	.6%
Total	1,213	100%	118,501	100%

Hospital Based

	Facilities	Percentage	Beds	Percentage
Investor Owned	50	22.0%	1,609	13.1%
Not-for-Profit	129	56.8%	6,995	56.8%
Governmental	48	21.1%	3,716	30.2%
Total	227	100%	12,320	100%

Combined

	Facilities	Percentage	Beds	Percentage
Investor Owned	1,078	74.9%	105,780	80.9%
Not-for-Profit	308	21.4%	20,574	15.7%
Governmental	54	3.8%	4,467	3.4%
Total	1,440	100%	130,821	100%

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (2001)

TABLE 4.

Facilities by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	1,026	1,025	1,032	1,028	1,034	1,028
Not-for-Profit	187	180	175	171	172	179
Governmental	4	4	4	4	6	6
Total	1,217	1,209	1,211	1,203	1,212	1,213

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	60	70	64	56	56	50
Not-for-Profit	148	149	154	144	147	129
Governmental	54	53	47	49	51	48
Total	262	272	265	249	254	227

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	1,086	1,095	1,096	1,084	1,090	1,078
Not-for-Profit	335	329	329	315	319	308
Governmental	58	57	51	53	57	54
Total	1,479	1,481	1,476	1,452	1,466	1,440

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Occupancy Rates by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	86.5%	86.3%	84.9%	83.4%	82.5%	81.2%
Not-for-Profit	87.6%	86.6%	85.3%	86.3%	83.1%	81.6%
Governmental	79.9%	76.4%	84.4%	68.3%	60.8%	59.7%
Total	86.6%	86.3%	84.9%	83.7%	82.4%	81.1%

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	73.4%	68.0%	69.9%	70.4%	60.4%	57.1%
Not-for-Profit	75.3%	74.9%	74.4%	73.4%	71.7%	66.2%
Governmental	86.1%	81.4%	86.7%	86.8%	82.3%	80.1%
Total	78.3%	75.8%	77.1%	76.9%	73.3%	69.1%

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	86.3%	85.9%	84.6%	83.2%	82.1%	80.9%
Not-for-Profit	83.4%	82.5%	81.4%	81.6%	79.1%	76.3%
Governmental	85.3%	80.8%	86.4%	84.3%	78.5%	76.6%
Total	85.8%	85.2%	84.2%	83.0%	81.6%	80.0%

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Licensed Beds by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	102,437	102,587	103,521	103,974	105,161	104,171
Not-for-Profit	13,187	13,246	12,531	12,104	12,600	13,579
Governmental	1,177	547	547	547	751	751
Total	116,801	116,380	116,599	116,625	118,512	118,501

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	1,613	2,074	1,914	1,649	1,671	1,609
Not-for-Profit	7,128	7,146	7,189	6,985	6,852	6,995
Governmental	3,780	3,798	3,475	3,497	3,587	3,716
Total	12,521	13,018	12,578	12,131	12,110	12,320

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	104,050	104,661	105,435	105,623	106,832	105,780
Not-for-Profit	20,945	20,392	19,720	19,089	19,452	20,574
Governmental	4,957	4,345	4,022	4,044	4,338	4,467
Total	129,322	129,398	129,177	128,756	130,622	130,821

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 4.

Patient Days by Year

Freestanding

	1996	1997	1998	1999	2000	2001
Investor Owned	32,367,700	32,253,066	32,010,046	31,580,031	31,761,391	30,957,649
Not-for-Profit	4,425,991	4,194,112	3,910,033	3,821,196	3,818,040	4,065,365
Governmental	159,960	152,559	168,589	136,434	167,012	163,570
Total	36,953,651	36,599,737	36,088,668	35,537,661	35,746,443	35,186,584

Hospital Based

	1996	1997	1998	1999	2000	2001
Investor Owned	415,711	503,324	509,546	434,659	364,376	334,361
Not-for-Profit	1,954,421	1,929,995	1,927,391	1,874,702	1,798,975	1,693,335
Governmental	1,161,144	1,138,048	1,103,483	1,119,568	1,072,921	1,057,420
Total	3,531,276	3,571,367	3,540,420	3,428,929	3,236,272	3,085116

Combined

	1996	1997	1998	1999	2000	2001
Investor Owned	32,783,411	32,756,390	32,519,592	32,014690	32,125,767	31,292,010
Not-for-Profit	6,380,412	6,124,107	5,837,424	5,695,898	5,617,015	5,758,700
Governmental	1,321,104	1,290,607	1,272,072	1,256,002	1,239,933	1,220,990
Total	40,484,927	40,171,104	39,629,088	38,966,590	38,982,715	38,271,700

Source: OSHPD Annual Utilization Reports for LTC Facilities and Hospitals (1996-01)

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Authority	Summary	Reasons
Omnibus Budget Reconciliation Act of 1987 (OBRA 87)	Federal	Medicare Medi-Cal	Monitoring Approach • Outcome-based compliance measures • Focus on appropriate assessment and care planning • Responsive to residents' wishes, capabilities, and changing status • Consistent approach nationwide Reimbursement • Reasonable costs for services rendered	• Major public and media concern about poor quality treatment of some nursing home residents
SB 679, Mello (Chapter 774, St. of 1991) Elder Abuse Civil Protection Act (EDACPA)	State	All Long-Term Care	Cases of Elder Abuse • Reasonable attorney's fees and costs • General damages for a decedent's pain and suffering ($250,000 cap) • Exception to Probate Code, allowing damages for a decedent's pain and suffering • Provisions for punitive damages	• Recognition that Medical Injury Compensation Reform Act of 1975 (MICRA) contained provisions that discouraged elder abuse litigation actions
New Federal Regulations (1995) to implement OBRA 87 Requirements	Federal	Medicare Medi-Cal	Resident Assessment Instrument (RAI) • A standard assessment protocol to identify residents clinical, care, and social needs • Minimum Data Set (MDS), a core set of elements that form the foundation of comprehensive assessment Enforcement • Standard enforcement terminology (scope and severity) • Additional enforcement remedies • Revised standard survey processes to determine applicable action	• Improve quality and consistency of the resident assessment process • Improve consistency of enforcement • Encourage compliance through variety of sanctions.

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
Balanced Budget Act of 1997 (BBA)	Federal	Medicare	Prospective Payment System (PPS) • Payments changed to prospective rate • Per diem payment for each Medicare resident, adjusted to reflect differences in resident characteristics and service needs	• Curb escalating health care costs
New Federal Regulations (1998) to Implement OBRA 87 Requirements	Federal	Medicare Medi-Cal	MDS • Automated transmission of resident assessment data • Begin phase-in of PPS • Some states use MDS/PPS in their Medicaid rate system	• Utilize data to streamline survey process • Focus on poor performing facilities • Create quality indicators that build acuity into monitoring systems • Enable calculation of rates consistent with acuity of residents
AB 1107 (Chapter 146, St. of 1999)	State	All SNFs	• Increased minimum nursing staff requirement to 3.2 hours of direct patient care per day effective January 2000	• Improve quality of care in nursing homes
Balanced Budget Refinement Act (BBRA) of 1999 Benefits Improvement and Patient Protection Act (BIPPA) of 2000	Federal Federal	Medicare Medicare	• Temporary “add-ons” for some per diem reimbursements for nursing homes • Include a temporary increase of 20% for 15 categories of residents, largely addressing medically complex patients • Many of “add-ons” sunset September 2002	• Mitigate the severity of the rate reductions caused by PPS

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
AB 1731 (Chapter 451, St, of 2000)	State	All SNFs	• Empower Consumers & Their Families ⇨ Enhanced Complaint System ⇨ Health facility information on internet ⇨ Increased posting of enforcement actions • Supporting Caregivers ⇨ Budget increases for nursing homes to benefit caregivers and improve quality of care ⇨ Increase focus on minimum staffing standards ⇨ Technical assistance to nursing homes to improve quality ⇨ Quality awards to nursing homes that provide exemplary care • Enforce Tough Licensing Standards ⇨ Facility reporting of alleged or suspected abuse within 24 hours ⇨ Facility financial reporting requirements ⇨ DHS Financial Solvency Advisory Board ⇨ Increase fines for violations of licensing standards ⇨ Increase frequency and unpredictability of surveys ⇨ Establish temporary manager enforcement option	• Improve quality of care • Acknowledge relationship between staffing and quality of care • Acknowledge the importance of incentives to support quality performance • Acknowledge the importance of protecting residents from abuse • Acknowledge the relationship between financial stability and quality care

TABLE 5.

POLICY & REIMBURSEMENT CHANGES AFFECTING NURSING HOMES

Statute/Regulation	Federal/State	Medicare/Medi-Cal	Summary	Reasons
AB 1075 (Chapter 684, St. of 2001)	State	All SNFs	• Create mechanism to increase minimum staffing requirements to level that assures high quality care • Require staffing standards to be converted from hours per patient day to a ratio of patients per direct caregiver. • Implement a facility specific Medi-Cal reimbursement system.	• Improve quality of care • Easier for residents and their families, facility employees, and state inspectors to monitor for compliance. • Rates that reflect costs and staffing levels associated with quality care.

[1] *Social Security Act,* Section 1819 (b)(2).
[2] The Health Unit*,* op.cit.
[3] Jane Tilly, et.al., *Long-Term Care: Consumers, Providers, and Financing - A Chart Book, Urban Institute* March 2001. pp. 34,36.
[4] "HHS to Provide Nursing Home Quality Information to Increase Safety and Quality of Nursing Homes" (press release), *HHS News*, U.S. Department of Health and Human Services, November 19, 2001. www.hhs.gov/news/press.
[5] Tommy Thompson, "Letter to The Honorable J. Dennis Hastert, March 19, 2002. nccnhr.newc.com//uploads/H&Hmarch19.
[6] Carole Fleck, "Nursing Home Care is Found Wanting," in *AARP Bulletin,* Washington, D.C., April 2002, p. 7.
[7] "Nursing Home Liability Insurance Rates: Factors Contributing to the Rate Increases in Texas," *Brief,* Senate Research Center, Austin, TX, February 2001, p. 5.
[8] *Nursing Homes Aggregate Medicare Payments are Adequate Despite Bankruptcies,* U.S. General Accounting Office, GAO/T-HEHS-00-192 (Washington D.C.: GPO, 2000), p.1.
[9] Cartwright, op.cit.
[10] Johnson, op.cit.
[11] "The President's FY 2003 Budget," *Federal Activities Report,* CalPERS, April 23, 2002, www.calpers.ca.gov/whatshap/legislat/activities .